

HEALTHCARE REFORM IN THE UNITED STATES: WHY STRUCTURES MATTER

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ABSTRACT

AMARA JOCELIN BOOTH: Healthcare Reform in the United States: Why Structures
Matter

(Under the direction of John D. Stephens)

In 2008, the year Barack Obama was elected president, nearly fifty million people in the United States did not have health insurance. Of those who did, 102 million had plans which covered neither their illnesses, nor the medications they needed, sufficiently (Hellander 2008). Many of the people who did have coverage became aware of the limits of their policy only after they became sick and were told by their insurance company that their condition would not be covered. Soon after his inauguration, President Obama made clear that reform of the healthcare system would be a key legislative priority for his administration. Other presidents before him had attempted such reform, and each time they had come up short. Their failure was, in large part, due to the structural and institutional composition of the United States, which presents formidable obstacles to those attempting to overhaul the system. This paper explores the uniquely American experience with healthcare, focusing on the institutional and structural impediments reformers have faced on the road to reform.

DEDICATION

To my mom, Ann Booth, who has always been and always will be the most important person in my life. And, to Caroline Park, whose love and devotion mean the world to me. Thank you both for your encouragement and support throughout this process.

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CHAPTER 1

INTRODUCTION

There is nothing more difficult to manage, more dubious to accomplish, nor more doubtful of success ... than to initiate a new order of things. The reformer has enemies in all those who profit from the old order and only lukewarm defenders in all those who would profit from the new order (Niccolò Machiavelli quoted in Wilsford 1994: 251).

These words, written hundreds of years ago, paint an accurate picture of the way attempts at healthcare reform in the United States have gone in the 20th and 21st centuries. Major reform attempts were undertaken by Lyndon B. Johnson in the 1960s, by Bill Clinton in the 1990s, and by Barack Obama in 2009/10. This list is by no means exhaustive; many others, Republican and Democrat alike, have tried to change the system, and all have faced uphill battles. And, while some attempts have been successful, the vitriol with which opponents have attacked both proposed legislation and its proponents has been, at once, spectacular and puzzling. Moreover, since the end of World War II, most attempts at healthcare reform have failed, which has served to further legitimize the strategies employed by those opposed to change, and led many to question whether the United States will ever fully implement a universal healthcare system. This skepticism is certainly warranted, and in this paper I argue that the difficulty in achieving major reform in the United States is owed in large part to its structural and institutional composition, both of which present formidable obstacles to anyone attempting to overhaul the healthcare system. In the first section, I discuss federalism, and compare Canada and the United States in order to highlight the

opportunities and constraints presented by the federalist structure of government; in section two, I examine the presidential system of government, the lack of party discipline inherent to it, the ways in which this system allows elected officials to pursue their own political self-interests and be influenced by interest groups, and how this has hurt attempts at major reform; in the third section, I examine the two party system in the United States, the ways in which it creates an inhospitable environment for the emergence of third parties (including a social democratic party), and how the absence of this type of third party has impeded the passage and implementation of a national healthcare plan in the United States; in the fourth section, I explore the road to, and eventual success of, the Patient Protection and Affordable Care Act; in the fifth section, I conclude. It is my hope that an analysis of these areas will help answer the question: Why has major healthcare reform been so difficult to achieve in the United States?

CHAPTER 2

HEALTHCARE REFORM AND THE FEDERALIST STRUCTURE IN THE UNITED STATES AND CANADA

The process of healthcare reform in Canada and the US has differed greatly, both in terms of processes and outcomes, since the end of World War II. This is somewhat surprising given the many major similarities the two neighbors share – both are stable democracies; both hail from Anglo-Saxon roots, and are liberal market economies; the structure of both governments is federalist; both share common religious and cultural traditions; and, both are advanced industrial welfare capitalist states. As such, these two nations are archetypical for a Most Similar Systems Design of research. In this section, I compare the federalist structure present in the United States to that which exists in Canada. It is my hope that such a comparison will shed light on the ways in which the American “brand” of federalism has, and continues to, impact healthcare reform efforts in the United States.

The Federalist Structure

The Constitution of the United States lays out a federalist framework whereby power is divided between the federal government, and those of the individual states. Similarly, the British North America Act of 1867, which provided for confederation of Canadian provinces, delineates the distribution of powers between the national government (the Parliament) and the provincial legislatures. Since the end of World War II, attempts to introduce major reforms to healthcare have been undertaken in both Canada (in the 1950s, and again in the

1960s) and in the United States (in the 1960s, 1990s, and in 2009/10). Of significant consequence to healthcare reform in both Canada and the United States, was/is the federalist structure of government that exists in each. However, despite a similar division of power, the outcome of reform attempts in the two countries has been divergent. In Canada, the provincial-federal relationship has significantly influenced the emergence and evolution of the Canadian system (Maioni 2002). Here, the federalist structure has promoted a climate of interaction between the two levels of government that has helped ameliorate the kind of volatility described in this paper's opening quote by Machiavelli. Conversely, Machiavelli's words nicely sum up what has taken place in the United States during each of the attempts at major reform. The successful passage of the Obama Administration's Patient Protection and Affordable Care Act (PPACA) notwithstanding, the healthcare reform process in the United States has been consistently plagued by ambiguity over jurisdiction. Inherent to the federalist structure is the division of power, but where healthcare is concerned, there lacks in the US, a consensus as to which entity ought to have provisional and fiscal authority: the states or the federal government. State-level solutions are likely to have limited success, due to the constraints of the federalist structure; and federal-level solutions have been hampered due to a seeming (and understandable) lack of political willingness to undertake sweeping reform efforts (Bobinski 1990).

Conversely, in the Canadian brand of federalism, there exists no ambiguity: constitutional jurisdiction over the administration and financing of healthcare is clearly delineated, and lies exclusively with the provinces. For decades, this structural reality has opened windows of opportunity for reformers in Canada to pursue policy change at the provincial level (Tuohy 1999).

Red Light, Green Light: Federalism as Traffic Cop

Political institutions in the United States are not designed to support or encourage expansive reform. The institutions are highly fragmented, with power divided between a strong judicial branch, the Senate, the House, multiple executive departments, and the White House. This fragmentation offers a menu of veto points to groups and powerful individuals seeking to influence (or derail) reform efforts.¹ The division of authority between these entities is *in addition* to that prescribed by federalism. Given this political environment, it can be said that when major reform passes in the United States, it happens in spite of institutional and federalist structures, not because of them.

Over the years, healthcare policy entrepreneurs have faced uphill battles as they have sought to find ways to work through and around the constraints posed by these structures. In the case of the passage of Medicare (and Medicaid), it took a national tragedy to bring about a window of opportunity within which President Johnson was able to act. The assassination of President Kennedy produced a temporary shift in the political context, one which Johnson immediately recognized and seized upon. He realized that in the few months following Kennedy's death, Members of Congress would be unlikely to vote against legislation that was tied to the fallen Kennedy (Tolleson-Rinehart 2010). Johnson's window of opportunity was further widened in 1964, by his landslide victory in the presidential election, coupled with Democratic control of both the Senate and the House of Representatives. Combined, these circumstances were a political coup for Johnson, enabling him to overcome the obstacles his proposed reforms faced, just long enough to get them passed. However, the federalist structure present in the 1960s could not support Medicare and the expenditures and coordination it would entail. Johnson and the other reformists involved had to find a way to

¹ See Immergut (1990) for her groundbreaking introduction and discussion of veto points.

surmount this challenge, and did so via a substantial expansion of the federalist structure to include actors beyond federal and state governments. His administration's expansion of existing programs, and the initiation of new ones, meant that the private sector, along with quasi-government and traditional government agencies, were eligible for grant funds. In some instances, assistance bypassed states and went directly or indirectly to local governments, some of whom saw a three-fold increase in their funding (Walker 1974). That the implementation of Medicare required a significant expansion of the federalist structure of government is a poignant reminder of the constraints it, along with institutional barriers, can pose to efforts at major policy reform in the United States.

In Canada, federalism has, on occasion, stifled efforts at healthcare reform too; however, it has also provided important opportunities for progress and innovation (Maioni 1998). In particular, because Canada's Constitution grants the provinces jurisdiction over healthcare, reform in this area has been much less volatile than in the United States. In the following sub-section, I will elucidate upon the ways in which Canada's brand of federalism allowed the federal government to fashion its national healthcare plan based on those already up and running in several provinces, Saskatchewan in particular.

Federalism and Healthcare Reform Outcomes

In the 1960s, Canada experienced economic prosperity, and Ottawa and the provinces enjoyed good relations. Even those between Ontario and Quebec were solid, which had not always been the case. The late 1950s saw the implementation of government-sponsored hospital insurance, and in 1966, the Medical Care Act, which extended coverage beyond hospital care to include comprehensive medical insurance, was signed into law. The policy design of both programs was heavily influenced by that already in existence in several

provinces. Under the social-democratic Cooperative Commonwealth Federation (CCF) government, Saskatchewan was the first to adopt a comprehensive plan in 1962, followed by Alberta, which in 1963, implemented a program to help low-income individuals pay for private insurance. Soon after, British Columbia and Ontario developed programs designed to offer their residents an alternative to purchasing insurance from private companies (Tuohy 1999). The Canadian brand of federalism facilitated and encouraged this type of design and implementation of universal hospital and medical insurance at the provincial level. Further, it provided a mechanism by which the public medical and hospital insurance innovations, conceived of at the provincial level, could be diffused across the entire nation (Maioni 2002). Progressive provincial governments, such as the CCF in Saskatchewan, were instrumental in this process. In addition, the notion that healthcare ought to be accessible to everyone, without regard to financial means, enjoyed broad public support. Physicians were also widely amenable to the legislation, because it allowed them to maintain control over clinical decision making, even if some limitations were placed on their entrepreneurial capacities (Hutchison, Abelson, and Lavis 2001).

In the United States, federalism does not offer the same facilitative mechanisms for major healthcare reform; nor do the institutions. In the decades following the end of World War II, several states attempted to address healthcare and faced uphill battles. The challenges can be sourced, at least in part, to federalism. As states have endeavored to address the issues of access and cost, their efforts have been hurt by federalism doctrines which impede the ability of individual states to regulate the healthcare market (Parmet 1993). In addition, when states do seek the autonomy necessary to develop reforms, they often experience push-back and competition from interest groups operating at the national-level.

This is so because most meaningful state-level reforms, especially those which are healthcare-related, require federal funding, which means the states must obtain Congressional approval. This has pitted states against the influential, well-funded lobbyists who aggressively advocate on behalf of the private interests they represent in Washington. In this match-up, states are often at a disadvantage, with their reform goals frequently subjugated by the desires of powerful interest groups and their lobbyists with direct access to Members of Congress.²

This reality notwithstanding, states have, on occasion, served as “laboratory experiments” for social policy. Reforms enacted in one state can have a demonstration/replication effect on others, especially when the changes are shown to be substantively, financially, and administratively feasible (Nathan 2005). In addition, when one state successfully implements reform, it gives reform-minded strategists in other states useful insight into how to neutralize opposition, and garner public support for their efforts. That the individual states are in a unique position to influence healthcare policy outside of their borders, whether intentionally or not, is quite evident. And, while the ability of state legislatures to implement healthcare reform at the state-level is impeded by the federalist structure, when states do experience reform successes, others are likely to follow in their footsteps. Moreover, as demonstrated by the universal health plan conceived of and implemented in Massachusetts, in 2006, under then Governor Mitt Romney, it is possible for progressive reforms undertaken at the state-level to be adopted at the federal-level. However, instances of this type of policy adoption, especially where major healthcare-related reform is concerned, are quite rare in the United States, especially when compared to its

² See Laguarda (1993) for a thorough discussion on the state-level healthcare reform efforts attempted in Hawaii and Oregon.

northerly neighbor. Perhaps then, the issue is less about innovation, or even about implementation. Maybe the challenge in establishing a universal healthcare program in the United States is in overcoming the ambivalence surrounding the very notion that government, be it state or federal, ought to be part of the provision and funding of healthcare, at all.

Despite the many similarities between Canada and the United States, there has been significant divergence between the two where healthcare policy is concerned. In this section, I have explored this issue through the lens of federalism, in an effort to illustrate the ways in which federal-provincial/state relationships and interactions have, and continue to, influence healthcare policy in the two neighboring countries. Through this comparison, I hope to have teased out some of the specific hurdles the American “brand” of federalism presents to those attempting to make major reforms to the healthcare system. In the next section, I turn to a discussion of the presidential system of government in the United States. Here, I will explore how the lack of party discipline, which emerges from this system, leads elected officials to pursue their own political self-interests and leaves them open to influence by lobbyists and interest groups.

CHAPTER 3

THE PRESIDENTIAL SYSTEM OF GOVERNMENT

Under the presidential system, the executive branch of government exists alongside, but separately from, the legislative branch. Accordingly, in the United States, the president is elected independently of the Members of Congress. In theory, this system is designed to provide checks and balances on the power of both branches, and while it serves that purpose, it can also lead to political impasses, as has been the case with healthcare reform attempts. Further, the separation of power in the American presidential system often impedes broad, sweeping reform, favoring instead smaller, incremental change. As a result, contentious but often important parts of proposed legislation are removed in order to push through at least some measure of reform. Such was the case with the portion of the Patient Protection and Affordable Care Act dealing with the planning of end of life care for patients on Medicare. This portion of the legislation simply allowed physicians to bill Medicare for the time they spent discussing end of life options and care with patients and their families. Items discussed during such visits might include: what a patient suffering from a chronic illness can expect in their final days; whether or not the patient wants to remain at home with hospice care; and whether or not the patient wants to assign decision-making authority to a loved one in the event they become unable to make decisions on their own. However, with the help of conservative strategist Betsy McCaughey, Sarah Palin was successful in stirring up controversy around the bill by equating this particular provision to a “Death

Panel.” In the end, despite the completely unfounded claim that this portion of the bill would cut off care for the critically ill as a means by which to save money, Democrats agreed to drop it from PPACA, in order to push the legislation through.

Although the “Death Panel” case is an extreme example, the presidential system does foster an environment in which ordinary Americans and groups wishing to influence the policy-making process can do so (Palin began making the “Death Panel” claims in 2009 as a private citizen, after she and McCain lost the election in 2008). And, while Sarah Palin is not your run-of-the-mill American, the system does provide the average citizen a means by which to actively engage the political process. This system also offers members of the legislative branch a broader palette of options from which to choose, as compared to their cohorts in parliamentary systems, who are fully expected to toe their respective party line. In this section, I will explore the opportunities and constraints posed by the presidential system, and the ways in which attempts at major healthcare reform have thus been affected.

Party Discipline

In the American presidential system, political parties have always been weaker than their cohorts in parliamentary systems. Members of Congress are prime targets of wealthy lobbying and interest groups, and often, these groups prove more important to a candidate’s (re)election than do the parties to which a candidate or incumbent belongs. In the U.S., Congressional Members have a strong incentive to place greater emphasis on the wishes of wealthy campaign donors than on the directives of their party (Huber and Stephens 2001). This reality was illustrated in 1974, when Vice-President Gerald Ford initiated a new move toward establishing a national healthcare plan.

The country had just been rocked by the Watergate Scandal, President Nixon had

resigned under disgrace, and the general perception of government was that it lacked integrity and was incompetent. Ford, along with several influential Members of Congress, saw undertaking major reform of the healthcare system a means by which to repair their reputation in the eyes of their constituents. Wilbur Mills, Chair of the powerful House Ways and Means Committee, and instrumental figure in the successful passage of Medicare in the mid-1960s, was put in charge of the effort. Despite overwhelming support for the bill in general, a consensus on the issues of cost and mandatory participation could not be reached. As a result, Mills concluded that there was no point in bringing the bill to the House, since such a weak consensus within his committee signaled a sure failure in the House of Representatives. Mills reasoned that strong consensus in his committee was critical “because of the traditional absence of party discipline in this great federal republic” (Mills cited in Steinmo and Watts 1995: 354). Despite the respect and authority he held, even Mills was powerless in getting the members of his own committee to toe the party line. Without the type of party discipline which is present in parliamentary systems, substantial reform to the American healthcare system has been stymied. As the 1974 case illustrates, even when there is broad consensus among political elites, an entire piece of legislation can be stopped in its tracks when individual legislators, often spurred by (wealthy and influential) interested parties, begin haggling over a bill’s minutiae.

Another area of concern which arises from the lack of party discipline inherent to the presidential system of government is the possibility, even probability, that the Congressional majority will be comprised of the party opposite that of the president. Further, even when a single party holds the Executive Office and both Houses of Congress, consensus on legislation, especially when it is expansive, is far from guaranteed. As a result, unlike in

parliamentarianism, *partisan* majorities do not always lead to *policy* majorities in the United States (Oberlander 2003). An example of this phenomenon can be found in the near non-passage of PPACA in 2010, despite a Democrat as president and Democratic control of the House, as well as the Senate.

As mentioned earlier, in addition to impacting party discipline, the presidential system of government also opens doors to individuals and groups who are interested in influencing elected officials, especially Members of Congress. As a result, many interested parties have enjoyed, and taken full advantage of, the opportunity this access grants them to throw their two cents into the decision-making process. In the following sub-section, I elucidate further upon the extensive role interest groups have played in American healthcare reform debates.

The Impact of Interest Groups: The Clinton Case

On September 22, 1993, President Bill Clinton stood before Congress and gave a nationally-televised speech about the state of healthcare in the United States, during which he introduced his ill-fated healthcare reform bill, the Health Security Act (HSA). Initially, the response was overwhelmingly positive. Millions watched the address, and polls taken immediately following its broadcast indicated strong support for Clinton's plan. In addition, the Clinton's enjoyed the support of many Congressional Members from both parties (Skocpol 1997). A year later, the Health Security Act was declared dead. The bill's demise was largely attributable to special interest groups which received funding from a variety of industries who, combined, generated \$800 billion a year (The Center for Public Integrity 1994).

With so much at stake, those who felt they stood to lose if the legislation were to

pass, launched myriad attacks designed to dismantle the proposed bill. Without delay, various stakeholder groups began sending their members notifications which painted the HSA in a negative light. In addition, some of these groups formed coalitions, which funded attack ads and public polling efforts, intended to sway public opinion against reform (Skocpol 1997). One of the most commonly used refrains against the HSA was that the passage and implementation of a national healthcare plan would mean that decisions about a patient's own health would be taken away from them and their doctors, and instead be made by faceless bureaucrats employed by an ever-growing federal government. Conspicuously absent from such claims was any mention that there was already a robust, inefficient, and for-profit bureaucracy controlling much of the healthcare landscape in the United States, that being insurance companies. For patients who are covered by health insurance, virtually no decision by either a healthcare provider or a patient is made without a great deal of consideration of what will, and more importantly what will not, be covered by a given insurer. Concerned about what the Health Security Act might do to business, several insurers came together to present a united front against the plan. One such group was the Health Insurance Association of America (HIAA), made up of small and medium-sized insurance companies. This group was very influential, even after many of its smaller members and a handful of its largest, left to form their own associations in the early 1990s. The HIAA employed several strategies in its battle against the Health Security Act, including making the claim that any expansive reform to healthcare would necessarily result in the loss of jobs. In order to get their message across, the association used their well-established network of contacts and substantial resources to target small businesses, insurance company employees, older citizens, and veterans' groups, asserting that the HSA would mean tighter bureaucratic

controls and would result in the loss of jobs (Skocpol 1997). The suggestion that the passage of a bill will cost jobs, especially in the small business sector, can be very effective, particularly when the economy is poor and unemployment rates are high.

In addition to enjoying a wide range of connections in the private sector, HIAA also benefitted from the adept leadership of Willis Gradison, a Republican who left his position in Congress and on the Sub-committee on Health of the House Ways and Means Committee, to take the position with HIAA. Under Gradison, the association made it clear to Clinton that he could expect its continued support so long as the bill would allow HIAA's members to continue to "cherry-pick" who it insured. By employing this tactic, the insurance companies were able to keep premiums low for their customers because they only extended coverage to the healthiest applicants. The Clinton Administration refused to include such language in the bill and in short order, HIAA produced damaging attack ads replete with assertions that the Health Security plan would lead to socialized medicine. The HIAA was also responsible for the now infamous series of advertisements featuring Harry and Louise, a white, middle-class couple in their forties, who are pictured in their home lamenting the Clinton plan. These ads were influenced by the soap opera genre, did not look at all like a political campaign message, and cost a lot of money to produce. Only the Pharmaceutical Research and Manufacturers Association spent more than the Health Insurance Association of America (\$14 million) on their efforts to stop the Health Security Act (Goldsteen, et al 2001). In the advertisements, Harry and Louise appeared supportive of universal coverage. They "agreed with the president on healthcare for everyone," but the problem was "in the details" (quoted in Goldsteen, et al 2001: 1332). By scripting the message in this manner, the ad's writers

made sure the Harry and Louise characters aligned well with the majority of the public who found it troubling that tens of millions of Americans lacked adequate access to healthcare.

These advertisements illustrate another specific strategy that has been used by those opposed to reform: the claim that they are not opposed to reform, in general; just *this particular reform*. In this way, some of the fiercest, most ideologically extreme opponents have been able to frame their position as one of willingness to compromise, just not on certain details. In so doing, they are able to present themselves as moderates, whose views are in keeping with those of mainstream America.

The most potent, influential individuals and groups opposed to Clinton's healthcare reforms were well-funded, well-organized, and effective in their endeavors to dismantle his Administration's proposed plan. Such had also been the case during attempts at reform prior to the 1990s, and was certainly the case in 2009, when Obama rolled out the Patient Protection and Affordable Care Act. In addition to running advertisements, organizing marches and protests, mailing pamphlets, making phone calls, and engaging the media, groups interested in impeding or promoting a particular agenda enjoy a degree of access to legislators that surpasses that which is available in countries with parliamentary government systems. Hospital associations, medical equipment and device manufacturers, doctor associations, drug companies, and as mentioned, insurance companies are all well aware of this opportunity, and are eager to exploit the advantages the presidential system of government provides them. But what is it about this latter system that allows interested parties to influence the decision making process? In the following sub-section I will explore the ways in which American presidentialism fosters an environment which is conducive to interest group involvement at the policy-making level.

Presidentialism: Interest, Access, and Influence

As discussed earlier, the American system of government does not promote party discipline, and there is often little incentive for a politician to strictly adhere to any policy measure that is unpopular in her/his district. As such, if a group which is opposed to a particular proposal can convince a sufficient number of elected officials that their constituents are not in favor of said legislation, it is certainly possible, if not probable, that these legislators can be counted on to vote in line with the group's wishes. Interest groups seek to assure elected officials of voters' preferences by offering "proof." One such way to provide it is by conducting polling, as was done by the more well-endowed groups opposed to the Clinton reforms (Skocpol 1997). After carefully selecting sampling data indicating that likely voters were opposed to the Health Security Act, these groups would then submit the findings to the Members of Congress whom they expected would be influenced by the results.

Another means by which to assure legislators that the interest group is providing accurate information on where constituents lie on an issue is for it to hold and record meetings, rallies, and marches in which substantial numbers of expected voters are in attendance. For example, the Tea Party Movement is a large group of likely voters that claim to be non-partisan, but are consistently opposed to most of the proposals made by the Obama White House. This movement enjoys a significant amount of airtime in the mainstream media, both in coverage of its rallies and by mention in interviews with members of both the Democratic and Republican parties, as well as by political pundits. Special interest groups opposed to PPACA often cite the loud, boisterous, and committed Tea Party Movement (which is considered by many to be an interest group in and of itself) to legislators as "proof"

that the majority of Americans are opposed to Obama's healthcare bill. In contrast, those who stand to benefit the most from a universal healthcare plan – the uninsured and underinsured – do not comprise a single, unified group such as the Tea Party, nor do they enjoy the financial support those opposed to reform have historically received from the medical-industrial complex (Oberlander 2003). The tens of millions of under- and uninsured Americans hail from various geographical, ethnic, religious, and political backgrounds. They have little in common, other than their lack of adequate health insurance, and the diversity of this sizeable American minority has consistently left it without a powerful lobbying group to advocate on its behalf. As such, the voices of the under- and uninsured often go unheard by Members of Congress, and are often drowned-out by well-organized, well-funded groups opposed to reform.

Another, and perhaps the most potent, means by which interest groups influence policy is through monetary contributions to campaigns. Procuring and maintaining financial support for campaigns is a never-ending part of a Congress Member's life, regardless of whether it is an election year or not. This is so because in order to have a chance at election, or re-election in the case of incumbents, a candidate's political campaign must be well-financed. And while many who aspire to Congressional office are independently wealthy and contribute significant amounts of their own money to their campaign efforts, most are also forced to seek and accept funds from private donors in order to remain relevant as candidates. Exorbitant amounts of money were spent during the 2010 general elections, and it seems unlikely that reforms to decrease campaign spending, or move toward public financing, will be undertaken any time soon. In fact, in its 2010 decision on *Citizens United v. Federal Election Commission*, the Supreme Court of the United States ruled that the

government may not restrict or limit campaign contributions by labor unions, corporations, or any other organizations in elections. In so doing, the Court expanded the extensive – and uniquely American – role private interests play in the policy-making process. Under this presidential system, where individual legislators rely heavily on donations, interest groups with money to spend can often find candidates and incumbents willing to sit down and listen to their views on the issues.

Unlike in parliamentary systems of government, the United States' presidential system has presented unique challenges to the various healthcare reform efforts that have been attempted in the decades following the end of the Second World War. The constraints of the separation of powers and the imperatives of partisan coalition building can and have hampered consensus on health reform. In a highly fragmented political arena, competition between the executive branch and the legislature can serve to stymie the development and implementation of significant reform. Furthermore, the absence of party discipline and the permeable nature of congressional politics allow opponents of universal coverage a greater role in the political process (Maioni 1998).

In the following section, I will turn to a discussion of the two-party system in the United States, the ways in which it discourages third parties, and how the lack of a social democratic party has hurt attempts at healthcare reform.

CHAPTER 4

THE ABSENCE OF A SOCIAL DEMOCRATIC PARTY IN THE U.S. AND ITS IMPACT ON HEALTHCARE POLICY

In the United States, electoral politics have been dominated by two parties throughout (almost) all of the republic's existence, with either a Democrat or a Republican winning every presidential election, and one or the other party controlling the Houses of Congress (Bibby and Maisel 2003). Over the course of American history, individual third party candidates have, on occasion, been competitive in Congressional races, however very few have actually won. Furthermore, since the end of World War II, third party candidates have, at best, stood only a slight chance at victory in just a handful of presidential elections – Strom Thurmond in 1948; George Wallace in 1968; John B. Anderson in 1980; Ross Perot in 1992, and again in 1996. Indeed, in the United States, it is almost impossible for a member of a party other than the Democrats or Republicans to gain a foothold in American politics. But, why? In the following sub-sections, I will address this question and, as was the case with federalism, will provide a comparison between the United States and Canada, which has an active social democratic party, in order to provide greater elucidation upon the ways in which the absence of a social democratic party can impact healthcare reform efforts.

Third Parties Need Not Apply

The United States has a single-member district electoral system, meaning that where elections are concerned, the winner takes all. Unlike with proportional representation, unless a candidate is first past the post, thereby winning outright, neither they nor their party

receive any representation. This poses an often insurmountable hurdle to third parties, because even if a party's candidates were sufficiently popular to carry several districts, it is not enough. The need to secure a majority of votes across a majority of districts presents a daunting challenge to candidates of third parties.

In addition, just getting one's name on the ballot can be an extraordinarily onerous task. Candidates must spend an inordinate amount of time and money soliciting voters to sign a petition just to be eligible to have their name listed on the ballot. This is so because unless your name appears on the ballot, your candidacy simply does not exist. While the number of signatures required to get one's name on a presidential ballot varies by state, the bottom line is that candidates must obtain over half a million signatures nationwide, in order to qualify. As Theresa Amato, who ran Ralph Nader's 2000 presidential campaign explains, meeting this requirement requires a Herculean effort.

If you are a campaign that is subject to a massive major-party attack ... you have to collect between double and triple the required number of signatures to inoculate against lawsuits and challenges. So a third party or independent campaign really has to collect 8,000 to 12,000 signatures a day. Now if you have ever tried to circulate a greeting card in your office or among family members to get people to sign on time for a birthday, or if you have tried to get signatures for a block-party permit, you may have a ten-thousandth of an idea of how difficult it is to collect this many signatures across fifty states and the District of Columbia (Amato 2009: 29).

Third party candidates also face having their campaign platform(s) hijacked by the major parties. This scenario plays out when the position a third party candidate takes on an issue garners considerable support among likely voters. In such cases, major parties look to capitalize on the popularity of that position by incorporating it into their own campaigns, thereby increasing their appeal to voters in favor of the particular platform. This can prove fatal to the third party candidate, as it can effectively remove their *raison d'être*. Throughout

American history, there have been multiple instances where the Democrats and Republicans have charted a policy course with the goal of luring support away from the Independent. The 1968 presidential election provides one such example, when former Governor of Alabama, George Wallace, proved a formidable opponent to Nixon, the Republican candidate. In this case, the pro-segregationist Wallace garnered a significant degree of support in several southern states, which alarmed both major parties and forced the Republicans to adopt a platform designed to appeal to southern whites opposed to desegregation and equal rights (Rosentone, Behr, and Lazarus 1996).

The challenges third parties face is but one of multiple explanations for the lack of a social democratic party in the United States. Lipset (1977) provides a thorough analysis of the vast literature on the issue in his perennial essay, “Why No Socialism in the United States?” In it, he explains that most hypotheses fall into one of two categories: the sociological, political and economic make-up of the American society; and, factors present within the individual progressive movements which have emerged over the course of American history. Lipset provides a comparison of Canada and the United States in which he explicates that socialists in Canada were able to form an electorally viable party, the Cooperative Commonwealth Federation, largely because unlike Roosevelt in the U.S., Canada lacked a charismatic reform leader. The absence of a Roosevelt-equivalent in Canada allowed the socialist movement to grow there during the Great Depression.

In the following discussion, I continue the comparison of Canada and the United States, with an analysis of the ways in which the lack of a social democratic party in the latter country has made provision of universal healthcare less likely than in the former, where such a party does exist.

Social Democratic Influence in Canada and the United States

Like the United States, Canada has never had a social democratic party in power at the national-level. This similarity sets both countries apart from the majority of welfare capitalist nations because social democratic leadership at the federal level is often correlated with well-developed welfare states. However, unlike the U.S., there has been a viable social-democratic party, which has been engaged in provincial and federal politics in Canada, since the 1930s (Maioni 1998). Furthermore, the labor movement has enjoyed a significant degree of influence in Canadian politics as a direct result of the presence of a third Left party. Conversely, in the United States, organized labor stuck to its nonpartisan conventions and chose not to pursue political relationships with the Left, at least not until well after its Canadian counterpart had chosen to do so. By then, the American two-party system was well-entrenched, and labor's only option was to align with the Democratic Party, which was/is ideologically Right of social democratic parties. As a result of the choices the labor movement in the United States made early on, it has not exerted the influence its cohorts in other industrialized nations have.

According to Navarro (1989), the lack of a powerful labor influence necessarily has a devastating effect on the establishment of universal healthcare. He contends that the creation of a national healthcare system in any nation is directly related to the existence and agency of the labor movement present in that country, and that the movement's authority is exerted via labor's economic and political instruments: unions and parties, respectively. In his insightful article, Navarro discusses the ways in which labor has sought to establish universal healthcare coverage in multiple countries, and more specifically, has endeavored to do so by disengaging benefits from the labor market. Labor's efforts have been at odds with the

capitalist class, which typically prefers occupational-related health insurance provided through private insurance companies. This model typically strengthens the employee's attachment to, and reliance on, the employer, while simultaneously reinforcing inequalities amongst wage-earners. By promoting these types of inequalities and sharp class distinctions amongst workers, status cleavages have developed, which thwarted the formation of broad class coalitions amongst laborers in the United States (Esping-Andersen cited in Navarro 1989).

The laissez-faire, capitalist convention has been, and continues to be, very strong in the U.S. Furthermore, the notion that one ought not rely on government for help, but should instead provide for themselves, is an ideology deeply ingrained in the American psyche. It was not until the Great Depression that the fallibility of the markets reared its head and created a window of opportunity for Roosevelt and his New Deal. However, even during this time of immense economic hardship, and the passage of FDR's reforms, the tradition of American self-reliance and individualism remained. Roosevelt's new contributory social programs were presented to the public as quasi-contractual agreements, whereby citizens earned their benefits by making individual contributions over the course of their working lives (Weir, Orloff, and Skocpol 1988). Rimlinger (1993), an advocate of the national values approach, argues that this focus on contractual rights is significant because it highlights the notion that the individual should not be rendered dependent upon the benevolence of the state. He contends that the American commitment to individualism and self-reliance led to an intransigent resistance to the provision of benefits and services by the government. This national values approach runs contrary to the position taken by social democratic parties, which value the principle of social-ownership over individualism (Constitution of the New

Democratic Party: Preamble). In fact, the presence of a social democratic party is, according to Huber and Stephens (2000), *the* defining factor in the public delivery of services and one of the key determinants of public funding for the provision of social welfare programs.

While, as mentioned above, Canadians have not elected a social democratic candidate to the Prime Ministership, these parties have and do exert significant influence at both the provincial and federal levels. Further, the presence of a viable social democratic party offers an alternative which is absent in the US, one which made possible the creation and implementation of Canada's national healthcare plan (Horowitz 1966).

Given the myriad obstacles standing in the way of meaningful reform in the United States, the passage of the Patient Protection and Affordable Care Act on March 23, 2010, is truly remarkable. Considering the erstwhile, yet ultimately ill-fated attempts at healthcare reform undertaken by previous administrations, how is it that the 44th President of the United States accomplished this monumental feat? In the following section, we examine the twists and turns on the road to the passage of PPACA.

CHAPTER 5

HOW PRESIDENT OBAMA GOT IT DONE

Forty-four days after his inauguration, President Obama invited representatives from the American Association of Retired Persons (AARP), the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), university professors, dozens of Members of Congress, and ordinary Americans to participate in his White House Forum on Health Reform (2009). In addition to these groups, the president also asked representatives from pharmaceutical companies, health insurance companies, physician associations, hospital associations, medical device and equipment manufacturers, and other business interests to participate. The purpose of this forum was to bring these varied groups together and to allow each of them a voice in the healthcare reform process. By extending an invitation to key industry players, Obama signaled his willingness to bring all relevant parties into the discussion, *especially* those who had mounted the most potent opposition during previous attempts at health reform. Where President Clinton had adopted a populist, anti-industry stance during his attempt at healthcare reform in the 1990s, President Obama rejected such industry-bashing, seeking instead to create a more hospitable environment, one in which big-business would be less likely to ally against him (Calmes 2009). Despite criticism from members of his own party, Obama remained stubbornly committed to cultivating a working relationship with these economic heavy-hitters, understanding that without an (uneasy) peace with them, there would be no reform (Jacobs and Skocpol 2010).

Beyond the lessons learned from previous Democratic presidents, Obama's strategy was also informed by the experience of his Republican predecessor, George W. Bush. In his successful attempt to pass the Medicare prescription drug benefit, Bush cut considerable deals with interest groups. Similarly, Obama understood that if he wanted to achieve success in his endeavors, he would have to be willing to make deals and come to compromises with all stakeholders, even if this meant alienating some of his base (Altman and Shactman 2011). President Obama's insistence on bringing all relevant players to the table early on, and his particular emphasis on keeping key health industry groups involved at every step of the process, was a key part of his strategy for success. The president was under no false illusions, accommodating stakeholders was an absolutely necessary part of getting "things done within the system as it is" (Axelrod quoted in Baker 2010: paragraph 8). Obama used every opportunity afforded him as president as he pushed for reform, including the use of the bully pulpit. In the speech he gave at the White House Forum on Health Reform (2009), the president answered critics who claimed that given the economic crisis, now was not the time to initiate major reform.

All it takes is one stroke of bad luck—an accident or illness; a divorce or lost job—to become one of the nearly 46 million uninsured or the millions who have healthcare, but can't afford it ... healthcare reform is no longer just a moral imperative, it is a fiscal imperative. If we want to create jobs and rebuild our economy, then we must address the crushing cost of healthcare this year, in this Administration (White House 2009: 1-2).

In tying universal healthcare coverage to economic recovery, Obama introduced what would become a common refrain and a crucial element in the selling of his plan: the bottom-line of physicians, health insurance companies, medical device and equipment manufacturers, pharmaceutical companies, and hospitals is best served when coverage is available to all Americans. Obama's strategy was clear: bring as many stakeholders, whether

friend or foe, to the table early in order to develop a plan that would ultimately enjoy the support (or at least minimize the opposition) of these groups. It seemed to have worked, because on May 11, 2009, six major players - the American Medical Association (AMA), the Advanced Medical Technology Association (AdvaMed), America's Health Insurance Plans (AHIP), the American Hospital Association (AHA), Pharmaceutical Researchers and Manufacturers of America (PhRMA), and the Service Employees International Union (SEIU) signed a letter in support of reform (Jacobs and Skocpol 2010). And, two days later in a press conference on the South Lawn of the White House, Speaker of the House Nancy Pelosi stated that she was "quite certain" healthcare "legislation will be on the floor by the end of July" (Pelosi 2009).

However, when on July 13, White House Press Secretary Robert Gibbs was asked about the president's desire to have a bill on his desk by the August recess, the Secretary struck a less-optimistic note on the timeline. He replied, "I don't think anybody was under the illusion that the whole process would be wrapped up by the beginning of August" (Gibbs 2009). As it turned out, Gibbs' pessimism was thoroughly warranted; an agreement would not be reached before the Congressional summer recess. Even with a Democratic president and Democrats in control of Congress, health reform, having been resurrected, was once again in a fight for its life.

The First Signs of Trouble

By the beginning of August, 2009, the economic crisis was front and center for almost every American. Millions had lost their homes, national unemployment rates hovered around 10% (Taranto 2009), and many whose life-savings were tied up in the stock market suffered devastating losses when the value of their investments plummeted. Despite the

president's assertion that now was the time to pursue universal healthcare, many citizens were angry and health reform made an attractive target upon which to unleash their frustrations. As was typical during the summer recess, representatives returned to their districts and held town hall meetings. Atypically, several of them erupted into rowdy and sometimes violent confrontations. In one such gathering, 1,500 people packed an event in a Tampa, Florida, suburb to meet with US Representative Kathy Castor and State Representative Betty Reed. The event quickly became a near riot, with scuffles breaking out and venomous rhetoric spewed toward proponents of reform (Fox News 2009). It was a scene repeated throughout the country. At some meetings, Obama was compared to Hitler by individuals carrying signs with swastikas, whereas others issued dire warnings of euthanasia and socialism (Altman and Shactman 2011). Media coverage of such hysterical claims, attack ads from the Right, and the insistence by former Alaska Governor Sarah Palin that Obama's plan would result in death panels, took its toll, and public support for reform began to wane. Despite this, as summer turned to fall and Members of Congress returned to Washington, healthcare reform continued to plod along.

A Determined President

On September 9, 2009, facing staunch opposition from those on the Right, as well as members of his own party who were pushing for more liberal measures, Obama addressed a nationally-televised Joint Session of Congress in which he outlined his plan. Up to this point, Obama had been criticized by some for not taking a more prominent leadership role in the process. This hands-off strategy, however, was well-calculated and came about as a direct result of lessons learned from Bill Clinton's experiences a decade and a half earlier. Many agree that Clinton had made a critical misstep when he chose to develop his plan

almost exclusively in the White House amongst his advisors, as opposed to including Congress in the process. This tactic left members of the House and Senate, even those of his own party, disenchanted and unwilling to get onboard with his plan (Altman and Shactman 2011). In contrast, Obama laid out the framework for his plan, but left it up to Congress to develop the specifics.³ While these details were still being hashed out within the House and Senate, Obama addressed Congress and the nation in the joint session (President 2009). In his speech, he touched on three key components:

- Those who have health insurance can keep it. Insurance companies will be prohibited from denying coverage for preexisting conditions and from dropping people when their care is deemed too costly. In addition, placing yearly and lifetime caps on coverage will no longer be allowed;
- The millions of Americans who do not have insurance will be able to obtain it through insurance exchanges in which they may choose from a variety of insurers competing for their business. Those who are still unable to pay for these plans, even at the more affordable rates, will be eligible for need-based tax credits to help offset the costs;
- Just as motorists are required to carry vehicle insurance, this plan requires all individuals to carry health insurance, and most businesses will be required to offer it to their employees. For the most impoverished, those who even with the help of tax credits can still not afford coverage, and for the vast majority of small businesses, an exemption will be provided.

While many predicted that Obama's efforts to reform healthcare would fail, given the bruising he and the Democrats had taken over the summer, and despite the political-risk to which his pursuits were exposing both him and the rest of his party, his stirring address signaled his unrelenting commitment to reform. But, Obama was not alone in his determination – Speaker of the House Nancy Pelosi (D-CA) and Senate Majority Leader

³ Five separate committees were charged with this task. Three House committees: Education and Labor; Energy and Commerce; Ways and Means. And, two Senate committees: Health, Education, Labor, and Pensions (HELP); and Finance.

Harry Reid (D-NV) remained steadfast, as well. But as time marched on and winter set in, the political will of even the most dedicated Democrats in the House and Senate would be challenged, and the patience of ordinary citizens watching it all play out on the 24/7 news reel would be thoroughly tried.

The House

By early November, 2009, the House committees charged with developing their version of the plan – the Affordable Health Care for America Act, H.R. 3962 – had completed their work, and a vote on the bill would be held the first Saturday of that month. The Democrats enjoyed a solid majority in the House of Representatives – 258-177 – but, despite this, getting the bill through the House would be far from a slam dunk. By now, the Republicans had adopted the same tactic the party had implemented with great success during the last attempt at healthcare reform under Clinton in the early 1990s. Under the leadership of Newt Gingrich, who was then the House Minority Whip, along with Texas Representative Dick Armey and William Kristol, chair of the Project for the Republican Future, GOP response to Clinton’s plan was simple: oppose it at every step, *regardless of its content and what it would mean for the American people*. The strategy of the GOP leadership in 1993-4 seemed geared more toward embarrassing the Democrats, than it was about discussing how to reform the system in the direction of universal coverage (Skocpol 1997). In the end, as discussed earlier, Clinton’s Health Security Act failed, due in large part to the success of the stratagem adopted by the Republican Party.

With present day House Republicans hoping for a similar failure on the part of Obama, and signaling their intent to mimic the tactics used in the 1990s, Pelosi knew she could not count on a single House Republican vote. That meant that she would need at least

218 Democrats of diverging geographical and ideological positions to sign on in order to pass the bill. She had members who were pro-choice and pro-life, some who were pro-labor and some who were pro-business, those who favored a single-payer system and conservative Blue Dog Democrats who favored a free-market approach (Altman and Shactman 2011). In short, she faced a daunting task in finding enough common ground to bring a sufficient number of them onboard.

Differences on several major issues threatened to derail the House bill, none the least of which was abortion. Of the 258 Democratic House members, about forty of them led by Bart Stupak (D-MI), opposed abortion. Specifically, they were concerned that insurance plans subsidized by federal funds, including those on the insurance exchanges touted by Obama in his September address to Congress, would be used to pay for abortion services. This, despite the care taken by Democratic leaders to strictly adhere to the spirit of the 1976 Hyde Amendment, which prohibits federal funds from being used to pay for abortions “except when it is necessary to save the life of the mother or when the pregnancy is the result of an act of rape or incest” (US House 1976). This, however, was not enough to assuage Stupak who, along with his like-minded colleagues, had enough votes to derail the entire reform process. As such, the Speaker, who was a liberal, pro-choice Democrat, had no choice but to entertain their demands. Stupak offered an amendment forbidding any insurance company who participated in the insurance exchange from covering all abortion services, since some individuals covered under these plans may be receiving federal subsidies to pay for them (US House 2009). With little room to maneuver, Pelosi reluctantly agreed to allow Stupak’s amendment to come to a vote, knowing full-well that she faced an uphill battle in trying to persuade the pro-choice members of the House to go along with it

(New York Times 2012). With great skill, and because of the respect she had earned over the course of her many years in public office, the Speaker convinced enough pro-choice members to vote for the Stupak Amendment. Days later, she restated publicly what had likely become a common refrain in her discussions with pro-choice Democrats: “This is not a bill about abortion; this is a bill about healthcare” (McMorris-Santoro 2009: paragraph 2).

On November 7, 2009, Stupak’s amendment passed the House by a vote of 240-194, making way for the vote on the Affordable Health Care for America Act, which followed shortly thereafter. And, with a vote of 220-215, the bill passed – Speaker Pelosi, hundreds of House Democrats, and one lone Republican (Anh Cao of Louisiana’s 2nd District) – had achieved a monumental victory in the push toward universal healthcare. The next stop on the road to reform was the Senate, and President Obama urged its members to “take up the baton and bring this effort to the finish line” (Obama quoted in Stolberg 2009: paragraph 1).

The Senate

Just as Pelosi had faced myriad challenges in her pursuit on behalf of universal healthcare, so too did her counterpart in the Senate, Majority Leader Harry Reid. Holding 58 of the 100 seats, the Democrats had the majority, and with the two Independent members caucusing with the Democrats, the party enjoyed a filibuster-proof super-majority. However, the simplicity of the math belies the difficulties Reid would face.

One of the key issues facing Reid was whether or not to include a public option in the Senate plan. The public option would establish a health insurance plan that is government-run and would offer individuals and businesses an alternative to private insurance. Because such an alternative would cost consumers less than plans offered in the private marketplace, insurance companies were vehemently opposed. They feared they would be forced to drop

their prices in order to compete, which would cut into the hundreds of millions of dollars they made in profit each year. In addition, and not surprisingly, Senate Republicans were also opposed. What was more problematic for Reid was that despite multiple attempts, the Chair of the Senate Finance Committee, Democrat Max Baucus of Montana, remained unsuccessful in his attempts to win over enough *Democratic* members to include a public option in the Senate bill. As such, it did not make it into the final bill.

Another area of contention was, again, abortion. Ben Nelson (D-NE) made clear his unwillingness to sign onto the bill unless additional restrictions were placed on abortion rights. Barbara Boxer (D-CA) and Patricia Murray (D-WA) stood equally firm in their defense of reproductive rights. Seven days before Christmas, all three, along with Chuck Schumer (D-NY) and Harry Reid were gathered in Reid's office trying desperately to reach a compromise, although Nelson was at one end of the office, while the two women were hunkered down in Reid's chief of staff's office at the other end (Kane 2009). After hours upon hours of negotiating, with both Schumer and Reid shuttling between the parties, an agreement was reached. Nelson secured the compromise that had ultimately been rejected in the House the previous month, meaning the Senate bill would now prohibit government funds from being used to pay for abortion services in any plan purchased from an insurance exchange. As such, anyone desiring such coverage would have to pay for it using their own personal funds. Furthermore, Nelson added a provision allowing any state to forbid the inclusion of abortion coverage in the insurance exchanges it set up, meaning that even if an individual wanted to use their own funds to pay for the coverage, it may not be available in their state (Altman and Shactman 2011). Staunch supporters of a woman's right to choose, agreeing to include such language in the Senate bill was, no doubt, difficult for Boxer and

Murray. However, at 10:30pm on December 18, they acquiesced and a deal was reached. Exhausted, Boxer and Nelson, who had not actually spoken during the intense negotiations, embraced. Within minutes Reid was on the phone to Obama, who was on Air Force One, returning from a summit on global warming: “We did it, Mr. President” (Kane 2009: paragraph 3).

The Senate bill was now coming closer to a vote, and there was cautious optimism among reform supporters that it would indeed pass. On the other side, Republicans were incensed and mounted every effort available in order to derail the process, including scheduling six procedural votes, which would require *every* Democratic Senator and *both* Independent Senators to vote in *each* one. If even one vote were lost anywhere along the way, the Senate version of the healthcare bill may not survive. Making it even more challenging for Reid to maintain his fragile super-majority was the weather – a blizzard hit Washington, dropping a record amount of snow and making travel perilous, right in the middle of the series of crucial votes (Ballisty 2009). With this as the backdrop, Reid brought the bill to the Senate floor on December 19. Republican Minority Leader Mitch McConnell responded by employing a common strategy used to delay legislation: he required the entire 383-page document to be read out loud, immediately following Reid’s introduction of the bill to the Senate floor (Altman and Shactman 2011). Seven hours later, once Senate aides had finished reading, the Republicans initiated a filibuster; Reid responded by scheduling a cloture vote for Monday, December 21, at 1:00am. This was a critical vote, because if all sixty senators were willing to return in the middle of a snowy night to vote for cloture, it was highly probable they would maintain their support all the way through to the end.

Shortly after midnight, senators from both parties began arriving, including the ailing

92-year old Robert Byrd (D-WV), who was wheeled in. And, perhaps in a gesture toward all those who had fought healthcare reform over the years, or perhaps one directed toward the Republicans who had publicly encouraged people to pray that “somebody can’t make the vote tonight,” Byrd, when his name was called, “shot his right index finger into the air as he shouted ‘aye,’ then pumped his left fist in defiance” (Milbank 2009: final paragraph). The motion for cloture barely passed with a vote of 60-40, and after several other attempts at delay, the Republicans agreed to proceed with the final vote. The date was set for December 24.

On Christmas Eve, Senator Byrd once again captured in gesture and in words the monumental nature of the moment and the years of hard-fought battles that culminated on this winter day. It is routine during Senate roll-call votes for Senators to simply raise their hand when their name is called and state either ‘aye’ or ‘nay.’ However, Senator Byrd broke with this tradition. When his name was called, he enthusiastically thrust his arm in the air, held up a single finger, and exclaimed, “This is for my friend Ted Kennedy – Aye!” (quoted in Altman and Shactman 2011: 313).

The final vote on the Senate healthcare bill was 60-39, and the results represented an enormous achievement for Democrats. However, there was still much work to be done after the Christmas recess, including reconciling the Senate and House bills. Reformers would continue to face formidable opposition and the loss of one of its greatest supporters, Senator Ted Kennedy (D-MA), would be felt even more deeply after the January 19, 2010, special election to fill his seat.

The Election of Scott Brown and Reconciliation

It became clear to most in the week leading up to the election between Democrat

Martha Coakley and the relatively unknown Republican, Brown, that it was plausible, if not probable, he would win. Nevertheless, his victory was shocking, given that Massachusetts is the bluest of the blue states, and that the seat's previous occupant, Kennedy, had held it for almost half a century. With the seat going to the GOP, the Democrats had lost their supermajority in the Senate, leaving Republicans, political pundits, and even some Democrats convinced that this was the end of the road for healthcare reform, and all but guaranteed Obama would be a one-term president.

Congressional Democrats floundered publicly in the weeks following Brown's election. Eventually, however, they, their progressive allies, and several key stakeholders that Obama had reached out to during his March 2009 healthcare forum, finally came together to redouble their efforts. Despite the initial shock and dismay, the Brown victory had ironically served to galvanize reformers, leading Congressional Democrats to cooperate more fully and to intensify their commitment to seeing health reform through to the end (Jacobs and Skocpol 2010). A key moment in the turnaround came on January 29, when Obama traveled to Baltimore to meet with GOP lawmakers gathered at a House Republican retreat. It was agreed by all parties, in advance, that discussions would focus on healthcare and that the event would be nationally-televised. Despite the hostile environment, the president agreed to take any and all questions asked of him. In his article, "Obama Goes To GOP Lions' Den -- And Mauls the Lions," journalist Sam Stein extolled Obama's performance, explaining that it "was at once defiant, substantive and engaging," noting that Obama scolded Republicans for playing petty politics, deflected their policy critiques, and corrected their misstatements (Stein 2010: paragraph 1). Several more televised events were held in which the president outlined the specifics of his plan (basically a summary of the

provisions the Senate and House had already agreed upon) and continued to publicly make the case for reform. With Obama doing his part, Congressional Democrats soon stepped up to the plate.

Having lost their super-majority in the Senate, Reid and Pelosi decided to pursue a shrewd two-step approach. First, the House would pass the Senate version of the bill, which now had a sidecar bill containing several key taxing and spending provisions that House members wanted included. Once it passed the House, it, along with the sidecar, were sent back to the Senate, where passage required only a simple majority (a process known as reconciliation). Several last minute details had to be addressed, including getting a handful of anti-abortion House members, led by Bart Stupak, on board. To do this, Obama agreed to sign an Executive Order reinforcing the prohibition on the use of government funding for abortion already contained in the legislation. This promise, along with the public support of tens of thousands of Catholic nuns and the Catholic Health Association, was enough to convince the Stupak holdouts to sign on (Jacobs and Skocpol 2010).

Success!

On March 21, 2010, the House passed the Senate bill – the Patient Protection and Affordable Care Act (PPACA), H.R. 3590 – by a vote of 219-212; and the side car bill – the Health Care and Education Reconciliation Act, H.R. 4872 – by a vote of 220-211. Two days later, President Obama signed PPACA into law. On March 26, the Senate passed the sidecar bill, through reconciliation, by a vote of 56-43. Four days later, President Obama completed the historic process by signing it – the Health Care and Education Reconciliation Act – into law. It was all, as Vice President Joe Biden stated, “a big f*****g deal!” (Herszenhorn 2010: paragraph 3).

The process, however, is not yet complete, with implementation of the various pieces of the Patient Protection and Affordable Care Act set to continue over the coming months. The process will not culminate until 2014, when the most controversial piece of the legislation – the individual mandate – goes into effect. Twenty-six states have filed a lawsuit challenging the law, and over the course of three days in late March, 2012, the Supreme Court of the United States heard oral arguments in the case, officially referred to as *Florida v. Department of Health & Human Services*.⁴ The individual mandate component of PPACA, which requires every American (except very low-income individuals who cannot afford it and/or those with religious objections) to obtain health insurance, takes effect January 1, 2014. In addition, by this date, all employers must offer health insurance to their employees (firms with fewer than 50 workers are exempt). Individuals and businesses that do not follow this rule will be assessed monetary penalties. However, when the mandate goes into effect, insurance plans will be much more affordable for at least two reasons: tens of millions of Americans will be purchasing new policies, which will drive costs down, and government subsidies and employer support will be made available to help make insurance more affordable for all (Jacobs and Skocpol 2010).

While the individual mandate has been red meat for those opposed to reform, it is neither radical, nor is it without precedent. The same principle underlying the mandatory purchasing of health insurance is the same long-accepted logic behind mandating the purchase of vehicle insurance: everyone is better off when the vast majority is insured, otherwise those who do have coverage end up bearing the costs for those who do not. If a

⁴ The 26 States in the lawsuit before the Supreme Court are: Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin and Wyoming (C-SPAN 2012).

person without medical insurance is treated at the hospital for a broken bone or a heart attack and cannot pay their bill, those costs are then spread out amongst those who do have insurance because doctors, hospitals, and insurance companies all raise the prices insured parties pay, in order to cover the money they lose on patients who are uninsured and do not pay. As such, the individual mandate is a necessary and commonsense part of the Affordable Care Act. The Supreme Court is expected to issue its ruling on the act's constitutionality in June, 2012.

CHAPTER 6

CONCLUSION

As I hope has been made clear in this essay, there is no single explanation for why major healthcare reform has been so difficult to achieve in the United States. That there are multiple contributing factors is not surprising given the complexity of the issue; the economic, social, and political implications involved; and the number of stakeholders concerned. In these pages, I have explored three areas that contribute to the explanation: federalism, the presidential system of government, and the lack of a social democratic party. By undertaking this analysis, it is my hope that a clearer picture of the challenges faced by those endeavoring to implement major reforms to the American system of healthcare delivery and financing has emerged. Given the long history of formidable obstacles to this type of reform, President Obama and Congressional Democrats deserve high praise for their success in passing this monumental piece of legislation.

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